The Development of a Sexual Assault Referral Centre

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In the latter half of 1975 there was growing disquiet in the feminist community in Perth about the way victims of rape were treated if they wished to make an official complaint to the Police. As a result of community and other pressures the formation of a sexual assault centre was discussed by a Cabinet sub-committee and a working party of Police, Crown Law and Health Department officials. Following these discussions the then Minister for Health the Hon. Ernie Baxter wrote in December 1975 to the Board of Sir Charles Gardener Hospital. This hospital was chosen for many reasons including the availability of staff in the emergency department throughout the 24 hour period and the proximity of the forensic unit of the State Health Laboratories.

The Board of Sir Charles Gardener Hospital agreed to establish a sexual assault referral centre in the hospital in mid-December 1975. Over the Christmas period there was extensive discussion with various groups in the community including the Women's Health and Community Centre, the Police Department, the Office of the Under Secretary for Law, and the panel of doctors who since October 1975 had voluntarily organised themselves into a team prepared to be on call to examine rape victims and whose departments in the hospital included the Emergency Departments, Psychiatry Department, Social Nursing, Administration, Public Health Department, Forensic Pathologist and Forensic Laboratory Technicians. As a result of these extensive discussions the Centre opened on 5th January, 1976 which gave us precisely three weeks from start to finish. When the Centre did open we hoped and prayed we didn't get too many patients because we weren't actually geared up for anything at all.

The objectives of the centre are:

1. To provide strictly confidential, sympathetic and appropriate care of the physical, emotional and social needs of the victims of sexual assault. This care should be made available until the resolution of all problems arising from the assault.

2. To assist the Police and Crown Law Department at the victims request and I would stress that, it is purely at the victims re-

quest, by the collection of relevant data and presentation of evidence.

3. To enhance greater community understanding and involvement in the problems of sexual assault, by promoting the clinic as a reference and referral centre for the community participating in the education of medical and legal practitioners, police officers, health personnel and other allied professions, and providing support function for those groups actively involved in assisting and protecting victims of sexual assault.
4. Conducting lectures and discussion groups in schools and community groups.
5. Conducting research into the area of assault. Alleged assailants are not the direct concern of the sexual assault referral centre and are not seen or examined by the panel of doctors.

Staffing the Centre

The sexual assault referral centre is staffed by a team of female counsellors and a panel of female doctors. The counselling staff consists of one full time social worker who co-ordinates the counselling team. This social worker has back-up from various other social workers in her department. The other counsellors on routine call for the sexual assault referral centre are women from the community, numbering four at present, who work on a sessional basis. These lay counsellors are chosen for their warm caring personalities. They do not have formal qualifications but are given special in-service training in crisis intervention and rape counselling. These lay counsellors are on call from home and they in fact cover the out of hours roster for the centre.

The doctors who volunteer for the panel are also given training especially in the forensic aspects of their work. Most of the doctors on the panel work in other areas in the community outside the Sir Charles Gardener Hospital but they answer calls from the Sexual Assault Referral Centre if they are available and when the need arises. The Doctors' training is undertaken by me as the senior doctor on the panel. I have a one session appointment at the hospital to act as medical and clinical co-ordinator for the centre and I do the training and co-ordinating of the medical panel. In the crisis situation the initial contact with each victim is always a team approach, doctor and counsellor together.

Funding and Finance of the Centre

Funding of the centre has been undertaken by the Board of Management of the Sir Charles Gardener Hospital. All the facilities, equipment and staff of the hospital are readily available to doctors and counsellors on the panel. The Forensic Division of the State Health Laboratory Services used to be at the same site on the Queen Elizabeth Medical Centre but the technologists have since moved away. A Forensic Pathologist and Forensic Technologist are always on call and able to be consulted by telephone or called in, should an urgent need arise to examine either victims or specimens.

The victim who comes to the sexual assault centre pays nothing; this service is entirely free.

Social workers involved with the sexual assault referral centre are employed and paid by the Hospital. The lay counsellors now receive a fee for their on-call duties at home. Once they are called out for a case they are paid on an hourly basis, and they are also paid for follow-up visits or court work.

The doctors receive a standard fee, one for new cases and two for follow-up visits. These fees are based on the AMA scale of fees.

How the Centre works

The Sexual Assault Referral Centre functions out of the Emergency Department and the Social Work Department of the Sir Charles Gardener Hospital but it does not have a separate physical location. (It doesn't have a sign saying "Sex cases seen here" or anything like that).

As the staff of the Sexual Assault Referral Centre are not always in the hospital the initial contact is preferably by telephone. When a telephone call comes through to the hospital switchboard there are two ways in which it is answered. In office hours the Sexual Assault Referral Centre social worker is available and she is on call anywhere in the hospital on her page. She goes to the nearest telephone and takes the call that comes through on the hospital switchboard and deals with whatever problem presents itself. After hours at night and during weekends the calls are answered by a senior nursing sister. There is always a special counsellor on call at home and the nursing sister either suggests to whoever is phoning in that they come into the hospital and meet the counsellor or if that doesn't seem appropriate then the nursing sister will phone the lay counsellor on her home number. The lay counsellor will then phone the client as we don't give out the lay counsellor's personal phone number to anyone who calls. Sometimes the calls are referred to a Doctor as well. It depends on the circumstances.

Obviously it would be ideal to have a counsellor always available to answer a hot line direct to the Sexual Assault Referral Centre but at present the number of calls we are receiving per week does not justify having a paid counsellor sleeping or living at the hospital overnight.

Whenever a crisis call comes into the hospital it is suggested to the victim that she comes in to the emergency department. Here the girl is met by the on duty counsellor and taken immediately to a quiet interview room.

When the girl is taken to this interview room usually she meets the on call doctor and together the doctor and the counsellor talk to the victim to establish her immediate needs and concern. If the Police have not been involved and the alleged rape is recent then the advantages and disadvantages of reporting the incident to the CIB are discussed in relation to the girl's own needs at the time. Everyone's needs vary and what might be appropriate for one girl does not apply to another as it would cause her a lot of social and other pressures.

The Sexual Assault Referral Centre's role is to support the girl in whatever decision she makes after due thought and consideration. Urgent medical problems always take preference over the forensic examination. However, if the girl has no serious injuries then the doctor usually proceeds fairly quickly to the clinical examination and collection of medical and legal evidence because we find that many women are terrified of this examination and what it entails. Once it is over they are more easily able to relax and can turn their minds to practical problems relating to the incident and focus on the emotional impact of the assault itself, without the fear of the examination clouding the issue.

I am sure you all know the details of the medical examination of rape victims. There are several good papers on the subject and I won't elaborate on it. The only comment I will make is that Dr. Lindsay Stewart and I did write a step by step guide on how to

examine a rape victim. It is like a cook book, absolutely steps from one to 101 in very easy lessons. This was published in the Australian Family Physician in November, 1978. There are reprints available on the table.

The 'Medical Issues' which are discussed at the initial crisis interview are:-

1. Physical examination and treatment of all trauma as required. Again reiterating that major physical trauma always takes precedence over any forensic examination.

2. Examination for forensic evidence, and collection of the appropriate samples and specimens. This is done only at the victim's request if he or she has reported the assault to the Police or is planning to do so. I will add that if they are not certain I will take any evidence that it is necessary to take at the time and I personally keep it and take it home. We have a fridge at home which I use to keep these specimens in. We keep them for 48 hours so that the girl does have that time to exercise her option of reporting it to the Police and the evidence is still available should it be needed.

3. The possibility of pregnancy and or V.D. and prophylaxis against pregnancy and venereal disease are discussed and offered if appropriate. Diagnosis and treatment is offered for a later stage. The medical follow-up occurs at varying intervals for up to twelve weeks.

The prophylaxis for pregnancy regimen that we follow is based on the work of Yuzpe from the United States. We give 2 tablets of Eugynon straight away in the crisis time as long as it is within 48 hours of one act of unprotected intercourse. One does go into whether they could be already pregnant and obviously then one wouldn't give hormonal treatment. So it is 2 Eugynon tablets stat and then a further 2 tablets in 12 hours time. Eugynon just happens to be the pill that came to the top of the list when we were looking for pills in the hospital pharmacy. I'm sure you all know that there are others that are identical in composition and obviously could be used instead.

Using this regimen we have had very few failures. If I looked through my notes I could find 4 over the last 4 years that I know have failed where the girl has become pregnant for one reason or another. The trauma of pregnancy resulting from rape is extreme and I personally offer this preventive regimen to every woman who does not have any other contraceptive cover at the time of assault, whatever the stage of her menstrul cycle. Certainly one of the girls that became pregnant was about day six of her normally three monthly cycle, so one would have hardly expected her to be ovulating, but she became pregnant and the dates fitted exactly with the incident.

We find that the regimen of 4 hormone pills cause very little in the way of side effects. Casual nausea and more infrequently vomiting, are the only side effects that I have ever actually noted.

Prophylaxis against gonorrhoea is also offered and the usual regimen is Amoxyl 3 grams, Probenecid 1 gram, 12 hours after the last hormone pills. If the pregnancy prophylaxis is required or if the girl is already on oral contraception Amoxyl in large doses can interfere with the effectiveness of oral contraceptives and so one has to be very careful not to take away the cover by giving large doses of Amoxyl at an inappropriate time.

Counselling the Rape Victim

The Sexual Assault Referral Centre in Perth will offer a one to one ongoing counselling service whereby the counsellor who meets the victim at the initial contact continues to be that girl's counsellor right through to the end of the counselling contact. Obviously this is the doctrine of perfection. Counsellors do leave the centre and so certain victims do have a change of Counsellor for that reason. Also if for any reason there is a personality clash, and this can happen, between the victim and the counsellor then a different counsellor's services are offered. The aim of the counselling contact is to assist the victim with any problems that occur as a result of the assault.

These may be practical, social, emotional or psychiatrical. The centre does not take on the victim's life problems. It assists only with such problems as are related to the assault.

During the initial crisis contact the counsellor always encourages a follow-up visit within 24 hours because we find the second contact within 24 hours is the time the victim has unwound and has had time to think about the implications and has many questions to ask of her counsellor. After this first follow-up the follow-ups are based on the needs and requests of the victim and the family. Counselling continues with the involvement of the same counsellor from the initial contact until all problems arising from assault are resolved.

The Counsellor also accompanies the victim to all Court hearings and other legal consultations if the victim so wishes. We have made arrangements in the courts that the counsellor is allowed to accompany the victim right into the Court. She doesn't sit besides her but she sits to the side or behind and is there, an invisible support. The girls do seem to appreciate this. All contact with the centre is strictly confidential. No one, parents, police, school, work, etc. are told of the victim's attendance at the centre and so they have the anonymity of being in a large general hospital.

Although the Sexual Assault Referral Centre has its own headed note paper for court reports and official notices, any medical certtificates or letters can be written on ordinary hospital paper and so keep this anonymity so the victim can say she had an accident or felt unwell and had gone to the Emergency Department. The victim has a free choice all the way through; whether to accept medical help, whether to report the incident to the Police, whether to tell parents or friends and whether to keep further follow-up appointments.

Follow-up Care

I've mentioned the follow-up care for counselling and in brief the medical follow-up of the three areas of interest which are; ongoing care of injuries, and if these are serious the girl is usually referred to an appropriate hospital clinic or inpatient team; the diagnosis of pregnancy, and the diagnosis of gonorrhoea, syphilis or other sexually transmitted diseases.

In order to diagnose gonorrhoea a follow-up visit, approximately 7 to 10 days after the assault is needed at which stage urethral and cervical smears and swabs are taken for bacteriological examination and culture. Swabs and smears are also taken from any other orifice involved in the assault, for instance the mouth or the anus. A second follow-up visit 4 to 6 weeks after the assault is needed to diagnose pregnancy. Finally a negative VDRL test after 90 days indicates that the girl has not contracted syphilis.

Briefly the number of cases referred to the Sexual Assault Referral Centre in the first year, January 1976 to December 1976 was 80. From January 1977 to December 1977 it was 76. As I said the centre was set up in a great hurry and publicity and public approaches to make ourselves known were very minimal in the early days. I think that would account for the numbers being approximately the same for the first two years. However, since then the numbers have increased. The next year we saw 112 and last year 163.

More detailed analysis

There was a specifiic analysis done of 11 months from November 1978 to September 1979, of 104 cases, of which 103 were women. That would be about the number we would see, for we rarely see male victims. It does tend to throw the whole system into a flurry because we are female workers but we always offer the men male counsellors or male doctors. In fact none of them have ever taken this up and have been quite happy to see the women. The incidents in 104 cases:

Incest	-	12 cases
Rape	-	75 cases
Indecent assault	-	6 cases
Carnal knowledge	-	6 cases
Other, oral sex, anal sex and attempted rape.	-	5 cases

The age range of the victims is 4 to 90 years. We do see some very young victims although we try to direct these to the children's hospital. We also have some very old victims but the majority of our cases is in the young sexually active group.

The breakdown is:

15 - 20 years	-	41 cases
20 - 30 years	-	34 cases

Making a total of 75 out of a total of 104 cases.

Sources of Referral

1 Police referrals, the bulk of our work, 51 cases.
2 Referrals from relatives, 6
3 Friends' referrals, 9 cases.
4 Self-referrals, 13.
5 19 cases Referred by G.P.'s, Ministers of Religion and other social agencies.
6 Remaining cases not filled in on the history card, 14.

Although 51 cases were originally referred by the Police 60 cases in fact had Police involvement. So 9 girls decided to go to the Police after they had come to the centre.

Education

The Sexual Assault Referral Centre within the confines of staffing and funding is becoming increasingly involved in the area of community and professional education. There is a close liasion bebetween the staff at the centre with both the uniformed police and the CIB. The medical and counselling co-ordinators are involved in lectures and discussion groups with all branches of the Police Department. There are also requests for talks in high schools and from other interested community groups.

The Sexual Assault Referral Centre has built up harmonious relationships with all hospital departments and with the Police. It is becoming more widely known in the community and as a result self-referrals are becoming more numerous, along with referrals

from other medical, social or counselling agencies. At first over 90% of our referrals were by Police request to examine rape victims or other victims of sexual assault, this figure is now more like 50-60%. The percentage will vary obviously from month to month. One area of concern still encountered by workers at the centre and more especially by the victim, is the one of legal proceedings.

The present laws relating to sexual assaults need reviewing including rape, indecent assult and incest. Legal proceedings are very long winded and cause severe emotional trauma to the victim because her story is closely examined by all legal personnel and the court proceedings often do not take place for at least six months after the assault. In Wesern Australia we are quite lucky that it is only six months but even so this is an awfully long time.

In our counselling we encourage the victim to face the trauma of the assault and not just block it out. To deal with it and then to return to normal living. However, she is unable to do this while legal proceedings still remain hanging over her. The need for a fair trial for the alleged assailant does seem to come into direct conflict with the needs of the innocent victim who requires peace, anonymity, a lack of harrassment and emotional support. No victim giving evidence at a court hearing emerges without suffering distress. In fact I would go so far as to say that every person giving evidence suffers some distress. This is a very controversial area and it is currently under discussion at various levels. In Western Australia, the Attorney-Generals' Department feels that they have done quite well by the victim in that she has protection against publication of her name. There is a provision for hand up briefs, although professional witnesses are allowed to hand up briefs in the lower court, the victim is usually not.

At the centre we do not feel that there is any easy answer to this conflict of needs. Personally, I feel that if people in general could only see that anyone who alleges that she has been raped is in need of help and is not usually a vindictive woman of loose morals, then there would be less need for anonymity and more sympathy for the victim. Any woman who is guilty of a false report or who embroiders an incident for personal gain is crying out for help and should be seen and counselled sympathetically, not judged harshly and in a moralistic way. If community attitudes could change, then the need for a rape victim to be anonymous to avoid stigma would not arise, and the need for a special centre for rape victims would evaporate.

Chairman Dr. Marsh

Would anyone like to ask Dr. Dellar some questions or make any comment at this stage?

Dr. Daniels

Are your Perth Feminists groups themselves happy with the system developed by you or do they feel they would like their own service?

Dr. Dellar

At the begining there was quite a lot of antagonism. They felt they were very middle of the road and some of the feminist counsellors who had organised an informal rape centre before this centre was set up did join the staff but they rapidly left again. I think there may still be some disquiet in radical feminist circles but certainly there has been very little noise from them for the last two years.

Dr. Marsh

I think that's been the experience in New South Wales. Some of the people who got in on the welfare side were a problem but I think most of them have moved on.

Dr. Treadwell

One of the problems I find is that there is no instruction of doctors on how to examine sexual assault victims. I was wondering if you lecture medical practitioners on this subject.

I think this is very important. All doctors in New Zealand are taught gyneacology and obstetrics but very little about the question of rape. We all have different methods of examination. Most Police Surgeons try to examine the girl in their own surgery to try and give her more friendly surroundings. This is because there have been cases in the public hospital where the examination of the assault victim has been delegated down to the most junior person who really hasn't the slightest idea how to conduct an examination which subjects the poor girl to further trauma.

I was interested to hear of your step-by-step publication. We have recently developed a sexual assault kit. One of the people who we discussed this with and who helped promote it was a woman in the DSIR who is responsible for the examination of the specimens. We put into the kit a step-by-step procedure which is available to the doctor and to the police officer and both these now find that this is a great benefit even though some of them have been examining rape victims for a long time.

As your referral centre is in Perth do you get people travelling into the centre because of the service available?

Dr. Carol Dellar

In the initial crisis obviously there isn't time to bring them to the centre to be examined. Unfortunately, Western Australia is vast and we can really only offer a service from the centre to the metropolitan area. That covers quite a wide area probably 50 miles all round in which Police would bring the victim to us. Outside that area there is really nothing except that the step-by-step guide has been circulated to all Western Australian Government District Hospitals throughout the State. I do get phone calls from doctors in these hospitals, sometimes in the middle of the night, more usually in the morning or evening, who say 'I have a rape victim coming in, I have your step-by-step guide but could you tell me x, y or z'. So we are being used as a reference centre to answer queries and, hopefully, help people in the country conduct better examinations.

I have worked with the police and they now have a handbook whereby the list of specimens to be taken is written out officially for the police officer. In fact the list is for him to show the doctor the specimens he requires, with a few reasons as to why they are needed But there is no counselling service. We have had several country girls referred to us. One was from Kalgoorlie who was referred by the Police for counselling over incest that was longstanding. She came to Perth for two or three weeks to have some counselling help. Just recently a girl brought herself down from Geraldton and presented herself at the Centre after a particularly vicious assault. She managed to keep it to herself over the weekend and came in on the Monday afternoon for the examination where she broke down in a flood of tears. Nobody had seen her in the interim. Obviously people remote from the Centre have to cope as best they can.

Dr. Marsh

Dr. Dellar, You did give a breakdown of rape, incest, carnal knowledge and so on. How do you classify rape in that way. Is it as a result of conviction?

Dr. Dellar

No. Those were all on the girls' story. The alleged details that she gave us. I would not necessarily count that all those cases that I have said are rape are in fact **legally** rapes. We at the centre would take the view that the story the girl tells us is true, within limits. We are there to support her on her feelings about it. I think there are many cases where the girl feels that she has been used, been taken advantage of, that she has been raped. That is, sex has been had without her full consent although in a legal sense I don't think this would ever stand up in court and I don't think one would obtain a conviction.

Dr. Marsh

How do the Police feel about this? Do they feel the chances of apprehending an assailant are reduced by possible delays in the system. The girl might wait up to 48 hours before making up her mind whether she is going to report it or not.

Dr. Dellar

I think at the beginning there was this feeling of antagonism that if a girl came to the Centre first perhaps the women would influence her and possibly make the Police task more difficult. We feel responsible about this and if a girl comes to us in the initial crisis stage having just been raped, in the discussion on whether she wishes to report it to the Police or not we always point out that delay will do damage to her case and that in Court it will be brought up that she had to go away and think about it before she decided this choice.

Dr. Marsh

Do you give any training to staff on Police requirements so that staff in your Centre are aware of the problems Police have investigating these cases? Security of evidence and so on.

Dr. Dellar

I think we all know a fair amount about Police procedure now. As far as training goes I am really only responsible for training the doctors. The way in which we do it is that we advertise, or through personal knowledge we approach people whom we feel might be suitable. First of all I meet the doctor concerned and talk to her. I go through a few of the points about security and confidentiality and the way the Centre works as a team approach. Then she will come in with me and watch me do an actual case. She will sit in the background and watch how everything works. The next time she will do the actual case and I will sit in the background and watch how she does it. After that she is on her own, although I am very often around Perth and can often answer a telephone call even though I can't actually go in myself. We find in fact that a rape examination is not really very difficult to do. It's just making sure that you have followed certain points. Security, labelling specimens correctly (we have special labels which help us to label the specimens so that they can't be opened again without it showing), handing them directly to the Police officer or in the case where I take evidence and hold it myself, handing it directly to the forensic technician.

Dr. Treadwell:

I am sure that at some stage you will be challenged over the sealing and labeling of specimen bottles. We used to see it with